HIBAC—Key Advisor to Medicare

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SINCE ITS INCEPTION, the Health Insurance Benefits Advisory Council (HIBAC) has served as a bridge of understanding and channel of communication between the health care community and the Medicare program. HIBAC does not make Medicare policy, but no regulation or major policy has gone into effect without thorough review and previous advice by this organization. In its continuing advisory function, HIBAC has assured the medical community an important voice and role in Medicare policy decisions and has helped mightily to cement relations between the government and the private sector.

As a measure of the care and thoroughness that HIBAC brings to its assignments, it should be noted that never has either of the two Secretaries of HEW under whom it has served disregarded or ruled contrary to any of the Council's recommendations.

Congress, in the Medicare law, provided for a Health Insurance Benefits Advisory Council which was established by then Secretary of Health, Education, and Welfare John W. Gardner in November 1965. Section 1867 of the law states that "for the purpose of advising the Secretary on matters of general policy in the administration of this title and in the formulation of regulations under this title, there is hereby created a Health Insurance Benefits Advisory Council which shall consist of 16 persons, not otherwise in the employ of the United States, appointed by the Secretary without regard to the civil service laws. . . . The members shall include persons who are outstanding in fields related to hospital, medical and other health activities, and at least one person who is representative of the general public." In capsule form, these two sentences give the nature and function of HIBAC.

Especially notable is the fact that this advisory council consists of private citizens and includes leaders in the health care field, as well as one or more representatives of the general public. Of equal note, in its advisory capacity, HIBAC does not establish the policies under which the program is administered; rather, it advises the Secretary of HEW with respect to the policies that are to be established.

The concept of establishing panels of private citizens to advise public officials on critical areas of administrative policy has long proven effective at every level of government. It was no surprise, then, that Congress would provide for such groups in enacting Medicare—a program that would affect the lives of millions of Americans and influence medical care in this country for years to come. Moreover, the Administration was in complete agreement with the Congress that the advisory role of HIBAC would be of vital importance to the implementation of the Medicare law.

I think that all of us who accepted appointment to the Council (HIBAC) in November 1965 appreciated the demanding task that lay ahead. Many of us, though, did not realize just how much time, effort, and energy would be required.

At its first meeting, 12 November 1965, the Council was called on to make recommendations on policy matters that would profoundly affect the delivery and reimbursement of health care services throughout the country. From the start, we were impressed by the fact that the Department of Health, Education, and Welfare wanted practical, down-to-earth advice — not platitudes or pious hopes — and needed it within the tight deadlines set up for launching the Medicare program.

Faced with this task, the Council met on 11 days in the first two and a half months after its establishment, and it has met nearly every month since. Many members, in preparing for the meetings, spent long hours in study or consultation with Government and health organization leaders. After

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presenting their views and findings at the meetings, the members decided — often (but not always) unanimously — on the recommendations that should be made to the Secretary concerning the policies to be adopted. These policies involved such complex subjects as conditions of participation and principles of reimbursement for hospitals, extended care facilities, home health agencies and independent laboratories, as well as reimbursement for physicians' services.

Unquestionably, this was a formidable task. However, my own confidence in the Council's ability to deal with this problem was enhanced by the qualifications of my fellow members. In appointing the Council, the Secretary provided for the broad representation of health care and other interests intended by Congress and, in addition, achieved a distribution of viewpoints, fields of competency and personal backgrounds that has assured full airing of all aspects of the policies considered by the Council.

The original Council members included:

Kermit Gordon, Chairman—Vice president of the Brookings Institution, an economist and a former director of the Bureau of the Budget. Mr. Gordon's term has expired.

William E. Beaumont, Jr.—Owner-administrator of Beaumont Nursing Homes of Little Rock, Arkansas, and past president of the American Nursing Home Association. Mr. Beaumont's term also has expired.

Bernard Bucove, M.D.—Health services administrator of New York City and former Director, Washington State Health Department; past president and former member of the Executive Committee of the Association of State and Territorial Health Officers.

Kenneth W. Clement, M.D.—Practicing surgeon, Cleveland, Ohio, and past president of the National Medical Association. Dr. Clement's term has expired.

Dorothy A. Cornelius, R.N.—Executive director of the Ohio State Nurses' Association and vice president of the American Nurses' Association. Miss Cornelius' term has expired.

Nelson H. Cruikshank—Former director, Department of Social Security, AFL-CIO, Washington, D.C., and past member of two advisory councils on social security.

C. Manton Eddy—Director of Aetna Insurance Company, Connecticut General Life Insurance Company and Connecticut General Insurance Corporation; past president of the Health Insurance Association of America.

Caldwell B. Esselstyn, M.D.—Associate program coordinator in the New York Metropolitan Regional Medical Program, the Associated Medical Schools of New York; former chairman and at present a member of the board of the Group Health Association of America.

Jose A. Garcia, M.D.—Practicing physician, Corpus Christi, Texas, and a member of the American Academy of General Practice. Dr. Garcia's term has expired.

The Very Reverend Monsignor Harrold A. Murray—Director, Department of Health Affairs of the United States Catholic Conference, Washington, D.C.; member of the President's National Advisory Commission on Health Facilities. Monsignor Murray's term has expired.

Russell A. Nelson, M.D.—President, The Johns Hopkins Hospital, Baltimore, Maryland, and past president of the American Hospital Association.

Howard P. Rome, M.D.—Senior consultant in psychiatry at the Mayo Clinic; councilor and past president of the American Psychiatric Association; professor of psychiatry, Mayo Graduate School of Medicine, University of Minnesota. Dr. Rome's term has expired.

Samuel R. Sherman, M.D.—Practicing surgeon, San Francisco, chairman of AMA Council on Legislative Activities and past president of California Medical Association.

Nathan J. Stark—Group vice president of operations of Hallmark Cards, and president of the Kansas City General Hospital and Medical Center Corporation.

Ray E. Trussell, M.D.—Director, School of Public Health and Administrative Medicine, Columbia University and former Commissioner of Hospitals for New York City.

Carroll L. Witten, M.D.—Immediate past president of the American Academy of General Practice and practicing physician, Louisville, Kentucky.

Ten new members have been appointed—seven to succeed those members whose terms have expird and three appointed in accordance with the Social Security Amendments of 1967 which increased the Council's complement from 16 to 19 members. The new appointees are:

Charles L. Schultze, chairman—Former director of the Bureau of the Budget, professor of economics at the University of Maryland and senior fellow with the Brookings Institution.

Margaret B. Dolan, R.N.—Professor and head of the Department of Public Health Nursing, University of North Carolina School of Public Health; member of the board of directors and past president of the American Nurses' Association.

Merrill D. Hines, M.D.—Medical director and chairman of the board of management, Ochsner Clinic; professor of clinical surgery, Tulane Medical School.

William R. Hutton—Executive director and director of information, National Council of Senior Citizens, Inc., and editor, *The Senior Citizen News.*

Syble H. Scott—Practicing attorney; nursing home operator; faculty member, School of Continuing Education, University of Oklahoma.

Herman M. Somers, Ph.D.—Professor of Politics and Public Affairs, Princeton University; past member of the Advisory Council on Social Security; consultant to many governmental and private agencies in the fields of administration and health services.

Adolfo Urrutia, M.D. — Practicing surgeon; chief of staff, Santa Rosa Medical Center, San Antonio, Texas.

Monsignor James Henry Fitzpatrick—Director, Division of Health and Hospitals, Catholic Charities, Brooklyn (N.Y.) diocese.

J. Minott Stickney, M.D. — Member of the faculty of the Mayo Foundation and the University of Minnesota.

Lionel F. Swan, M.D.—Practicing physician in Detroit, and immediate past president of the National Medical Association.

Throughout its first months of existence, the Council's agenda and priorities were dictated largely by the fact that the program had to be operational—with the exception of extended care services—by 1 July 1966. Consultation with the Council was required by law with respect to the conditions of participation for hospitals, home health agencies and extended care facilities. In addition, the Department sought the Council's advice on all other major policy areas before launching the program.

Before they were presented to the Council, of course, these matters were subjected to intensive study and consultation. The initial groundwork was laid by the staffs of the Social Security Administration, Public Health Service and Welfare Administration (now the Social and Rehabilitation Service) in consultation with experts in the health care community. Both the American Medical Association and the American Hospital Association established special committees to assist in this effort. Following these activities, work groups representing the viewpoint and experience of major professional and institutional interests were convened to review and refine the tentative policies that had been developed. These groups included persons suggested by medical, hospital and nursing home associations, insurance companies, Blue Cross and Blue Shield and public health organizations.

Typically, staff reports and pertinent background materials on each topic to be discussed are submitted to the members for study in advance of the meeting. Included is information on the legal framework within which policy must be adopted by the Secretary, the position taken by major interests and staff recommendations.

After preliminary staff discussions at the meeting, the Council begins the real hard core of its work. The members exchange opinions and reactions to the staff material, evaluating all aspects of the subject. If the members feel that they do not have an adequate basis for decision, they often request additional information from the appropriate Government agency or private organization. If they feel that there is sufficient basis for decision, but are sharply divided on what that decision should be, the members discuss possible alternatives that might prove satisfactory. Frequently, they request staff development of a number of such alternative proposals for presentation to the Council at a future meeting.

The time needed for the Council to reach a decision has varied widely. In some cases—for example, the conditions of participation for home health agencies—the members reached agreement on recommendations to be made to the Secretary after a single session. In other cases—for example, the principles of reimbursement for provider costs —many meetings, involving additional information and alternative approaches, were required before agreement could be reached.

There also has been wide variation in the nature of recommendations made by the Council. At times, a few critical issues of a policy could be isolated and recommendation geared to these issues. At other times, the Council has found it necessary to make its recommendations on a point-by-point, page-after-page basis. Examples of the latter include the conditions of participation for hospitals, extended care facilities and independent

laboratories, and the principles of reimbursement for provider costs.

The extent to which such a diverse group could reach agreement on so many complex issues seems nothing short of remarkable. However, on closer analysis, several factors have helped to shape this end result. First, of course, the statute itself limits the area of controversy. We were not considering, for example, whether or not there should be a Medicare law or what the provisions of such a law should be, but how the law as enacted might best be administered.

Secondly, we decided early to seek unanimity to the fullest extent possible after resolving different viewpoints. We felt that such an approach would be more useful to the Secretary than recommendations imposed by a majority, with a substantial minority in dissent (although this has occurred on occasion). In addition, this approach often forces the Council to find new and fresh solutions that often prove more acceptable to members than the positions they originally advocated.

Third, and I believe most important, the Council agrees on basic goals. While the members represent diverse viewpoints, they share the common goal of recommending program policies that are workable, fair and consistent with our mutual objective of high quality care.

The Social Security Amendments of 1967 contained several provisions which affected not only the size but also the functions of HIBAC. Among the most important were the previously mentioned increase in the number of members from 16 to 19, and transfer to HIBAC of all functions of the National Medical Review Committee (NMRC), which had not been appointed. Thus, in addition to its other responsibilities under Title XVIII, the Council has assumed the NMRC mandate "to study the utilization of hospital and other medical care and services for which payment may be made under this title with a view to recommending any changes which may seem desirable in the way in which such care and services are utilized or in the administration of the programs established by this title, or in the provisions of this title." In addition, the 1967 amendments require HIBAC to submit an annual report on the performance of its functions to the Secretary of HEW for transmittal to Congress, and to engage such technical assistance as required to carry out its functions.

To meet its new responsibilities the Council established an Ad Hoc Committee on the Evaluation of the Delivery and Use of Services under the chairmanship of Dr. Ray E. Trussell. In addition, to support the Commitee, the Council created task forces in the following areas: research and statistics; hospital and extended care services; home health services; medical services; and laboratory services. During the past several months each task force has been reinforced by ad hoc consultants appointed for service as necessary because of their individual competence, and/or because they would bring to HIBAC the views of important groups and organizations. Included among the consultants have been representatives of organized medicine, providers, the insurance field, and consumer organizations. This approach emulates the tremendous original efforts of the Social Security Administration to obtain maximum consultation in implementing Medicare. In this way, outside involvement will continue in the review, reporting and recommending process.

I hope that I have fully conveyed the fact that the Health Insurance Benefits Advisory Council is a vital, dynamic and ongoing group—one which has successfully helped to bridge the gap between the private and governmental sectors and one which has had an important voice in every Medicare policy.

In commending the Council for its contributions, HEW Secretary Wilbur Cohen said: "The successful launching of the Medicare program and its solid accomplishments . . . are due, in large measure, to the able and perceptive services of the Council's members. . . . I am grateful that we have had the benefit of their wisdom and special skills in this important undertaking. They have earned the gratitude of the Federal Government and of the millions of beneficiaries of the Medicare program."